B.5. Describe event or problem - continued

- 2600 MG A DAY.
9 FEB 00: THE PATIENT STARTED TAMIFLU THERAPY (UNSPECIFIED DOSE AND REGIME).
12 FEB 00 (EST): THE PATIENT DEVELOPED PROGRESSIVE CONFUSION AND DISORIENTATION SHE HAD EPISODES OF VISUAL HALLUCINATIONS AND HAD MARKED ANOREXIA WITH INABILITY TO EAT OR DRINK ADEQUATE LIQUIDS. ACCORDING TO HER HUSBAND THE PATIENT TOOK OTC-TYLENOL (ACETAMINOPHEN), APPROXIMATELY THREE TO FOUR TABLETS A DAY, UNSPECIFIED ROUTE (LESS THAN 2 GRAMS QD).
13 FEB 00: THE PATIENT WAS PRESCRIBED PROMETHAZINE (UNSPECIFIED DOSE, ROUTE AND REGIME) AT THE EMERGENCY ROOM. HER SGOT AND SGPT LEVELS WERE BETWEEN 3000 AND 5000 (NO UNITS, NORMAL RANGES OR BASELINE VALUES WERE SPECIFIED). TAMIFLU THERAPY WAS COMPLETED
UNKNOWN DATE: THE PATIENT WAS DIAGNOSED WITH DEHYDRATION, RENAL INSUFFICIENCY AND HEPATITIS. SHE WAS ADMITTED TO HOSPITAL.
14 FEB 00: THE PATIENT HAD HER LAST DOSE OF TYLENOL IN THE MORNING.
15 FEB 00: BASELINE CREATININE WAS UNKNOWN. THE PATIENT WAS TRANSFERRED TO ANOTHER HOSPITAL. THE PATIENT'S TEMPERATURE WAS ELEVATED, ALTHOUGH LOW-GRADE OF APPROX 100 DEGREES. THE PATIENT HAD NOT DRUNK ANY ALCOHOL AND HAD ONLY TAKEN HER USUAL MEDICATIONS. THE PATIENT DID NOT HAVE A RASH OR HEADACHE. THE PATIENT WAS STARTED ON AGGRESSIVE IV REHYDRATION. ACETAMINOPHEN LEVEL WAS 11. THE PATIENT'S VITAL SIGNS WERE: TEMPERATURE 97.1; PULSE 71; BLOOD PRESSURE 128/74; RESPIRATORY RATE 18; OXYGEN SATURATION 100% ON ROOM AIR. THE PATIENT WAS IN NO ACUTE DISTRESS BUT APPEARED SOMNOLENT AND CONFUSED. HEENT SHOWED PUPILS WERE EQUAL, ROUND AND REACTIVE TO LIGHT. SCLERA WHITE. OROPHARYNX SHOWED DRY MUCOUS MEMBRANES WITHOUT LESIONS. THERE WAS NO LYMPHADENOPATHY, THYROMEGALY OR JVD ON THE NECK. CHEST WAS CLEAR BILATERALLY. REGULAR HEART RATE AND RHYTHM, WITHOUT MURMUR, GALLOP OR RUB. THERE WERE 2+ PULSES IN ALL FOUR EXTREMITIES. ABDOMEN WAS SOFT, POSITIVE BOWEL SOUNDS, MILD RIGHT UPPER QUADRANT TENDERNESS TO PALPATION, NO SPLENOMEGALY. NO CLUBBING, CYANOSIS OR OEDEMA WERE PRESENT IN THE PATIENT'S EXTREMITIES. THE PATIENT HAD SCATTERED PURPURIC LESIONS ON BILATERAL EXTENSOR SURFACES OF THE ARMS. THE PATIENT'S CRANIAL NERVES WERE INTACT. DEEP TENDON REFLEXES 2+ AND SYMMETRIC. MOTOR STRENGTH SYMMETRIC AND GREATER THAN ANTIGRAVITY BILATERALLY. BUN WAS 64; CREATININE WAS 6.8; SGOT WAS 4134; SGPT WAS 1672; PH WAS 7.31; ALKALINE PHOSPHATASE 186. THE PATIENT HAD A CT OF HER HEAD WITHOUT CONTRAST WHICH SHOWED SCATTERED SUBCORTICAL AND PERIVENTRICULAR AREAS OF DECREASED ATTENUATION MOST CONSISTENT WITH SMALL VESSEL DISEASE, ALTHOUGH DEMYELINATING LESIONS OR OTHER PARENCHYMAL WHITE MATTER LESIONS COULD NOT BE TOTALLY RULED OUT. THE PATIENT ALSO HAD A PORTAL AND HEPATIC VENOUS DUPLEX WHICH WAS UNREMARKABLE AND AN ABDOMINAL ULTRASOUND WHICH SHOWED SOMEWHAT COARSE HEPATIC TEXTURE WHICH WAS CONSISTENT WITH EITHER FATTY INFILTRATION OR FIBROSIS AND MILDLY ECHOGENIC KIDNEYS CONSISTENT WITH A HISTORY OF CHRONIC RENAL IMPAIRMENT. THE PATIENT HAD A SERUM PROTEIN ELECTROPHORESIS AND A URINE PROTEIN ELECTROPHORESIS PENDING TO FURTHER WORK UP HER ANAEMIA. HER SMEAR WAS NEGATIVE FOR SCHISTOCYTES TO RULE OUT TTP. THE PATIENT'S MENTAL STATUS SLOWLY IMPROVED WITH APPROPRIATE SUPPORTIVE CARE. THE PATIENT HAD A NEGATIVE HEPATITIS PANEL. ALKALINE PHOSPHATASE WAS 186 IU/L, SGOT WAS 4134 U/L, SGPT WAS 1672 U/L, CREATININE 6.8 MG/DL, WBC WAS 6000 PER CC (NORMAL RANGE WAS NOT SPECIFIED), PCV WAS 27.3%, PLATELETS WERE 125000 PER CC, HEPATITIS C AB WAS NEGATIVE, HEPATITIS A AB WAS NEGATIVE, HEPATITIS B SURFACE ANTIGEN AND CORE ANTIBODY WERE NEGATIVE, ACETAMINOPHEN DRUG LEVEL WAS 11.3 (NORMAL RANGE 10 - 20) MCG/ML AND NORMAL SERUM PROTEIN ELECTROPHORESIS. THE PATIENT WAS ONLY GIVEN SUPPORTIVE CARE USING IV FLUIDS.
18 FEB 00: THE PATIENT'S LABORATORY VALUES WERE APPROACHING NORMAL, SODIUM 139; POTASSIUM 3.4; CHLORIDE 116; CO2 18; ANION GAP OF 5; BUN 11; CREATININE 1.1. HER LFT'S WERE RETURNING TO NORMAL WITH AN ALKALINE PHOSPHATASE OF 150; SGPT 308; SGOT 204. ALBUMIN 1.8. THE PATIENT WAS DISCHARGED FROM HOSPITAL. THE PATIENT'S MENTAL STATE SHOWED SIGNIFICANT IMPROVEMENT, SHE WAS NO LONGER CONFUSED. THE PATIENT WAS STILL MARKEDLY ANAEMIC AND REFUSED A TRANSFUSION BECAUSE THE ANAEMIA HAD BEEN A CHRONIC PROBLEM FOR HER. ALL PRESCRIPTION MEDICATIONS AND OVER-THE-COUNTER MEDICATIONS REMAINED ON HOLD. SHE WAS GIVEN A PRESCRIPTION FOR OXYCODONE 5 MG TABLETS Q12H PRN FOR HEADACHES. THE PATIENT WAS TOLD NOT TO DRINK ANY ALCOHOL. SHE WAS PUT ON A LOW SALT DIET. THE PATIENT NEEDED CLOSE FOLLOW-UP FOR HER MONOCLONAL GAMMOPATHY OF UNKNOWN SIGNIFICANCE. ALKALINE PHOSPHATASE WAS 150 IU/L, SGPT WAS 308 U/L, SGOT WAS 204 U/L AND CREATININE WAS 1.8 MG/DL. RESOLVING ABNORMAL LIVER TESTS. NO BONE MARROW BIOPSY WAS DONE BECAUSE HEPATITIS RESOLVED. TYLENOL DRUG LEVEL WAS DRAWN APPROXIMATELY 18 - 24 HOURS AFTER LAST DOSE.
24 FEB 00: THE EVENTS RESOLVED. TYLENOL WAS SUSPECTED IN CONTRIBUTING TO THE PATIENT'S ADVERSE EVENTS.
NO UNITS OR NORMAL RANGES UNLESS OTHERWISE SPECIFIED.
IT WAS REPORTED THAT THE PATIENT'S ELEVATED LIVER ENZYMES AND ACUTE RENAL FAILURE

WERE SECONDARY TO ACETAMINOPHEN HEPATITIS AND SEVERE DEHYDRATION. IT WAS CONCLUDED THAT CHRONIC LOW LEVEL USE OF ACETAMINOPHEN COULD PRODUCE SIGNIFICANT ELEVATION OF LIVER ENZYMES. IT WAS ALSO STATED THAT OVERALL THE PATIENT'S ILLNESS WAS MUCH MORE LIKELY DUE TO TYLENOL TOXICITY RATHER THAN TAMIFLU.
NO CAUSALITY ASSESSMENT FOR THE EVENTS WERE PROVIDED.

FURTHER INFORMATION RECEIVED ON 10 MAY INDICATED:
15 FEB 00: ALBUMIN WAS 2.7.
UNKNOWN DATE: AMMONIA WAS 10 UMOL/L (WITHIN NORMAL RANGE).
16 FEB 00: CREATININE WAS 3.3; BLOOD UREA NITROGEN WAS 42; ALKALINE PHOSPHATASE WAS 192; SGPT WAS 771, SGOT WAS 992 AND TOTAL BILIRUBIN WAS 1.3.
18 FEB 00: TOTAL BILIRUBIN WAS 1.1, ALBUMIN WAS 1.8. THE EVENTS RESOLVED.
THE PATIENT'S NEUROLOGIC STATUS HAD RETURNED TO BASELINE AT THE TIME OF DISCHARGE AND LIVER TESTS WERE NEAR BASELINE AT THE TIME OF DISCHARGE.
NO UNITS OR NORMAL RANGES WERE PROVIDED UNLESS OTHERWISE SPECIFIED.

B.6. Relevant tests/laboratory data - continued

SGOT
16-FEB-2000
LAB RESULT: 992
NO UNITS OR NORMAL RANGE PROVIDED.

SGOT
18-FEB-2000
LAB RESULT: 204 U/L

CT SCAN
CT SCAN OF HER HEAD WITHOUT CONTRAST SHOWED ONLY SCATTERED SUBCORTIEAL AND PERIVENTRICULAR AREAS OF DECREASED ATTENUATION MOST CONSISTENT WITH SMALL VESSEL DISEASE.

TEST_METHOD
15-FEB-2000
PH WAS 7 31

TEST_METHOD
15-FEB-2000
A PORTAL AND HEPATIC VENOUS DUPLEX WAS UNREMARKABLE.

TEST_METHOD
15-FEB-2000
THE PATIENT HAD A NORMAL SERUM PROTEIN ELECTROPHORESIS.

TEST_METHOD
15-FEB-2000
THE PATIENT HAD A URINE PROTEIN ELECTROPHORESIS. RESULTS PENDING.

TEST_METHOD
NEGATIVE HEPATITIS PANEL.

MAY 31 2000

TEST_METHOD
18-FEB-2000
LAB RESULT: 5
THE PATIENT HAD AN ANION GAP OF 5.

JUN 01 2000

SODIUM
18-FEB-2000
LAB RESULT: 139
NO UNITS OR NORMAL RANGE WAS PROVIDED.

POTASSIUM
18-FEB-2000
LAB RESULT: 3.4
NO UNITS OR NORMAL RANGE WAS PROVIDED.

CHLORIDE
18-FEB-2000
LAB RESULT 116
NO UNITS OR NORAMAL RANGE WAS PROVIDED.

CARBON_DIOXIDE
18-FEB-2000
LAB RESULT 18
NO UNITS OR NORMAL RANGE WAS PROVIDED.

ALBUMIN
18-FEB-2000
LAB RESULT 1 8
NO UNITS OR NORMAL RANGE WAS PROVIDED.

DRUG_LEVEL
15-FEB-2000
LAB RESULT 11.3
ACETAMINOPHEN LEVEL WAS 11.3 MCG/ML.

DRUG_LEVEL
LAB RESULT 11

ULTRASOUND SCAN
15-FEB-2000
AN ABDOMINAL ULTRASOUND SHOWED SOMEWHAT COARSE HEPATIC TEXTURE CONSISTENT WITH EITHER FATTY INFILTRATION OR FIBROSIS AND MILDLY ECHOGENIC KIDNEYS CONSISTENT WITH A HISTORY OF CHRONIC RENAL IMPAIRMENT.

ULTRASOUND SCAN NOS
15-FEB-2000
AN ULTRASOUND OF HER LIVER AND ABDOMEN WAS UNREMARKABLE.

WBC
15-FEB-2000
LAB RESULT 6000
NO UNITS OR NORMAL RANGE WAS PROVIDED.

PCV
15-FEB-2000
LAB RESULT 27 3
UNITS WERE %. NO NORMAL RANGE WAS PROVIDED.

PLATELET COUNT
15-FEB-2000
LAB RESULT 125000
UNITS WERE/CC. NO NORMAL RANGE WAS PROVIDED.

HEPATITIS_A SCREEN
15-FEB-2000
NEGATIVE

HEPATITIS B SCREEN
15-FEB-2000
HEPATITIS B SURFACE ANTIGEN AND CORE ANTIBODY WERE NEGATIVE.

HEPATITIS_C_SCREEN
15-FEB-2000
NEGATIVE.

ALBUMIN
15-FEB-2000
LAB RESULT 2.7
NO UNITS OR NORMAL RANGE WAS SPECIFIED.

ALBUMIN
18-FEB-2000
LAB RESULT 1.8

AMMONIA
1-FEB-2000 E
LAB RESULT 10 umol/L
WITHIN NORMAL RANGE.

CREATININE
BASELINE CREATININE LEVEL WAS UNKNOWN.

CREATININE
15-FEB-2000
LAB RESULT 6 8 mg/dL
NO NORMAL RANGE WAS SPECIFIED.

CREATININE
16-FEB-2000
LAB RESULT 3.3
NO UNITS OR NORMAL RANGE PROVIDED.

CREATININE
18-FEB-2000
LAB RESULT 1 1

CREATININE
18-FEB-2000
LAB RESULT 1 8 mg/dL

BLOOD UREA NITROGEN
15-FEB-2000
LAB RESULT 64
NO UNITS OR NORMAL RANGE WAS SPECIFIED.

BLOOD UREA NITROGEN
16-FEB-2000
LAB RESULT 42
NO UNITS OR NORMAL RANGE PROVIDED.

BLOOD UREA NITROGEN
18-FEB-2000
LAB RESULT 11

BILIRUBIN TOTAL
16-FEB-2000
LAB RESULT 1 3
NO UNITS OR NORMAL RANGE PROVIDED.

BILIRUBIN TOTAL
18-FEB-2000
LAB RESULT 1 1

ALK PHOSPHATASE
15-FEB-2000
LAB RESULT 186
NO UNITS OR NORMAL RANGE WAS PROVIDED. UNITS WERE IU/L.

MAY 31 2000

ALK PHOSPHATASE
16-FEB-2000
LAB RESULT 192
NO UNITS OR NORMAL RANGE PROVIDED.

DSS

ALK PHOSPHATASE
18-FEB-2000
LAB RESULT 150
NORMAL RANGE WAS NOT PROVIDED.

JUN 0 1 2000

SGPT
LAB RESULT 3000-5000
NO UNITS OR NORMAL RANGE WAS SPECIFIED.

SGPT

15-FEB-2000
LAB RESULT: 1672 U/L

SGPT
16-FEB-2000
LAB RESULT: 771
NO UNITS OR NORMAL RANGE PROVIDED.

SGPT
18-FEB-2000
LAB RESULT: 308 U/L

B.7. Other relevant history - continued

MITRAL VALVE PROLAPSE
HEMATURIA
MENORRHAGIA
MGUS

Medical History Text
THE PATIENT HAS NO KNOW DRUG ALLERGIES AND DOES NOT HAVE A HISTORY OF LIVER DISEASE. FAMILY HISTORY OF STROKE AND CORONARY DISEASE IN HER PARENTS. SHE DOES NOT SMOKE OR DRINK ALCOHOL.

E.1. Initial reporter (Name, address & phone #) - continued

PHONE [redacted]

G.8. Adverse event term(s) - continued

-MALAISE
-DIARRHEA
-TEMPERATURE ELEVATION
-CONFUSION
-DISORIENTATION
-VISUAL HALLUCINATIONS
-SOMNOLENCE
-ANOREXIA
-PURPURIC RASH
RENAL INSUFFICIENCY
DEHYDRATION
-RENAL FAILURE ACUTE
RENAL FAILURE ACUTE ON CHRONIC
-OLIGURIA